No. 89-1044

IN THE

# Supreme Court of the United States

OCTOBER TERM, 1989

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OCEAN STATE PHYSICIANS HEALTH PLAN, INC., *et al.*,
*Petitioners,*

v.

BLUE CROSS AND BLUE SHIELD OF RHODE ISLAND,
*Respondent.*

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**On Petition for a Writ of Certiorari to the United States Court of Appeals for the First Circuit**

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## BRIEF OF KAISER FOUNDATION HEALTH PLAN, INC. AS AMICUS CURIAE IN SUPPORT OF THE PETITIONERS

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### INTEREST OF AMICUS CURIAE

Pursuant to Rule 37 of the Rules of this Court, Kaiser Foundation Health Plan, Inc. ("Kaiser") files this brief as *amicus curiae* in support of the petition for writ of certiorari.[1]

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[1] Letters of consent from both parties have been lodged with the Clerk of the Court.

Kaiser is in the business of providing health care services, although in a different way than either the petitioner or the respondent. The Court of Appeals' opinion blesses a blueprint for monopolization in an important segment of the health care industry. Because of the dominance of Blue Cross-type plans in many markets, that pattern can easily be copied, through much of the nation, with devastating effect on incipient competition in the financing and delivery of health care services. Specifically, in markets that Kaiser participates in, Kaiser could easily be victimized by the same type of scheme that victimized Ocean State here.

Kaiser and its 11 principal subsidiaries are part of a group practice prepayment program often called "Kaiser Permanente," a term that identifies a number of organizations and the health care program that they conduct. Through its Health Plans, Kaiser enrolls members under agreements that require the contracting Health Plan to arrange or provide comprehensive prepaid health care services for its enrolled members. Kaiser arranges these services through other Kaiser Permanente organizations —Kaiser Foundation Hospitals and the Permanente Medical Groups. Health Plans and Hospitals are charitable organizations under I.R.C. § 501(c)(3). Health Plans are prototypical of comprehensive group practice prepayment plans, sometimes called "Kaiser-type" plans.

Kaiser represents one type of "non-traditional" health care program; its Health Plans assume responsibility for organizing and providing health care, not simply insuring its cost. Kaiser operates at both the insurer and provider levels, competing successfully on price with Blue Cross and the health insurance industry generally because of the cost savings effected at the provider level. These savings are real, because they result principally from appropriate utilization of health services (*e.g.*, where medically appropriate, the substitution of less expensive outpatient surgery for more expensive inpatient surgery). It is generally accepted that group practice

prepayment plans such as Kaiser provide care of equal or superior quality at lower cost than traditional indemnity programs that pay providers their fee-for-service charges.[2]

By contrast, the "traditional" form of a health care plan is the indemnity plan, typified by Blue Cross and Blue Shield of Rhode Island, that simply reimburses the cost (or part of the cost) of care. Under the traditional approach, the insurer serves essentially as a conduit that passes through to policyholders (in the form of premiums) the charges of providers—principally physicians and hospitals.

Some people, and a subset of nearly every employer group with whom Kaiser does business, demand freedom to choose from physicians not affiliated with a particular system. For this reason, among others, Kaiser developed the dual choice (or multiple choice) concept under which Kaiser normally will not participate in an employer's health benefits program unless eligible employees are provided a choice from among one or more other plans that do not limit choice of physician. The dual choice principle ultimately was incorporated as part of the Federal Employees Health Benefits Program, even though this program, as originally proposed, would have been conducted as a single nationwide indemnity plan. Under dual choice and multiple choice plans, federal employees, and many millions of other employees throughout the country, and their families, have the opportunity to

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[2] Frances C. Cunningham, and John W. Williamson, M.D., *How does the Quality of Health Care in HMOs Compare to that in Other Settings?: An Analytic Literature Review: 1958 to 1979*, The Group Health Journal, Winter 1980, P. 4; Harold S. Luft, Ph.D., *HMO Performance: Current Knowledge and Questions for the 1980s, A Research Agenda Considered*, The Group Health Journal, Winter 1980, P. 31; Willard G. Manning, Ph.D., et al., *A Controlled Trial of the Effect of a Prepaid Group Practice on Use of Services*, The New England Journal of Medicine, June 7, 1984, Vol. 310, Number 23, P. 1505.

choose from among significantly different approaches to financing and delivering health care.

Kaiser-type plans offer an alternative form of health care financing and delivery arrangement that would, if not thwarted by the exclusionary practices of a dominant indemnity plan, create active price, quality and product competition in the provision of health care services. Thus, there is every incentive for the dominant provider to nip their growth in the bud, before the alternative plans can grow to sufficient size to compete effectively. In this case, Blue Cross' market power was used to quash a developing HMO in Rhode Island. But it could just as easily be adapted to limit the growth of a Kaiser-type plan, virtually anywhere in the country.

Specifically, traditional indemnity plans of the Blue Cross-type are either (1) refusing with increasing frequency to contract with an employer if the employer offers Kaiser or another competing health care plan to its employees, or (2) imposing higher premiums for their traditional health benefits coverage—which many employers feel they "must" carry in order to offer unlimited "choice of physician"—unless the employer drops competing plans. Some traditional plans refuse to provide coverage to an employer group unless the competing plan's membership is frozen at current membership levels —resulting in no new members for the competing plan while the members it retains become older and sicker (and thus more costly to care for). These and similar tactics, virtually unheard of three years ago, place increasing pressure on employers to exclude competing health plans and have made them less attractive to employees. Thus, the opinion below, which insulates these tactics from antitrust scrutiny, threatens development of alternative methods of delivering health care services, and Kaiser's ability to compete and grow.

Plans such as Kaiser, irrespective of their financial strength, are particularly vulnerable if traditional plans

such as Blue Cross that offer unlimited choice of physician are permitted to engage in exclusionary practices like those sanctioned by the Court of Appeals. Because employers prefer to offer at least one plan that has unlimited choice of physician, most employers are unable to resist insurers' exclusionary demands. Indeed, if a traditional indemnity plan with unlimited choice of physician pressures an employer by threatening to cancel coverage unless the employer drops a competing Kaiser-type plan, employers will almost always drop the competing plan and retain the traditional indemnity plan because at least some of most employers' employees demand unlimited choice of physician.

Accordingly, as the principal offeror of "Kaiser-type" plans, Kaiser submits this *amicus curiae* brief in support of the writ of certiorari in order to highlight (1) the breadth and importance of this case, and (2) the respect in which the opinion below authorizes the exercise and maintenance of monopoly power.

## REASONS FOR GRANTING THE WRIT

### I. INTRODUCTION

This case presents two closely related issues about the abuse of monopoly power. *First*, it presents an important issue about the monopolist's use of monopoly power to impose higher costs on, or reduce supply to, incipient competition. *Second*, the case presents the related question whether the use of monopoly power to impose higher prices on those who must purchase the monopolist's services, unless that purchaser ceases dealing with a competitor—ordinarily regarded as "coercive" under the Sherman Act, 15 U.S.C. § 2—constitutes "coercion" under the McCarran-Ferguson Act, 15 U.S.C. § 1013, as well.

The Court of Appeals' endorsement of the actions of Blue Cross of Rhode Island offers a blueprint for monopolizing an important segment of the health care industry. The practices in question were found by a properly in-

structed jury to be part of an unlawful attempt to use monopoly power to maintain a monopoly. But in important respects, the opinion below substituted incorrect and insupportable notions of economic theory for findings of both anticompetitive intent and effect by a jury.

In recent years, this Court has rarely examined the limits of permissible anticompetitive conduct by a monopolist, particularly in the context of the monopolist *purchaser* of goods or services. But if the decision below is good law, it is fair to say that virtually nothing except predatory (i.e., below-cost) pricing would constitute an unlawful attempt to maintain a monopoly. Here, under the guise of efficiency, the lower court blessed a monopolist's decision to penalize a supplier if that supplier continued to supply the monopolist's incipient competition at a lower cost. The monopolist thus used its monopoly power over the supplier to disable a new entrant in the market by limiting the new entrant's supplies and raising its costs. That strategy might be permissible for an ordinary firm, but an ordinary firm could not afford to engage in that type of strategy, or expect to succeed with it if it tried. It was, however, a strategy employed here by a monopolist, effective only by virtue of monopoly power, and designed to maintain that monopoly position.

This case also concerns the scope of the McCarran-Ferguson exemption under Section 2 of the Sherman Act, where the conduct at issue is merely one part of a larger, demonstrable scheme to monopolize. The petition squarely presents the question whether a monopolist, which uses its market power to set prices that penalize customers for purchasing services from a competitor, is employing "coercion" of the kind forbidden by the Sherman Act and thus statutorily beyond the protection of the McCarran-Ferguson Act.

The important issues about the use of monopoly power presented by this case go to the heart of Section 2 of the Sherman Act. These issues are of immediate and broad

implication in the field of health care—which now consumes nearly 12% [3] of the gross national product, and where active competition is vitally needed as a restraint on burgeoning costs. It therefore presents a compelling case of both conceptual and practical importance that calls for review by this Court.

## II. THE COURT BELOW SANCTIONED A PARADIGM FOR MONOPOLIZATION AND FAILED TO UNDERSTAND THE POWER OF THE MONOPOLIST

It is conceded that Blue Cross and Blue Shield of Rhode Island held monopoly power, possessing a market share of at least 80%. Blue Cross had participation contracts with nearly 2,000 physicians, more than 90% of those in the State. Because of the number of participating physicians (which gives wide choice to employees), employers have a strong incentive to become and remain participants in the Blue Cross plan. Conversely, because of the large number of employees who are members of the plan, most physicians find it necessary to serve Blue Cross members or lose out on a significant proportion of the population.

In sum, because of its monopoly position, Blue Cross enjoys enormous power on both sides of the equation: It has power over physicians who supply necessary services. And it has power over employers who purchase health benefits coverage for their employees. This case involves the use of that monopoly power, again on both sides of the equation, in order to maintain that monopoly and quash competition.

When Ocean State entered the Rhode Island market with its HMO, it offered a plan that provided significantly broader benefits at a lower cost than Blue Cross. It accomplished this, in part, through cost containment strategies, including vigorous utilization review and phy-

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[3] Merit C. Kimball, *Nation's Health Bill to Rise 10.4% in 1990, U.S. Says*, Healthweek, January 8, 1990, at p. 1, Col. 1.

sician incentives. In providing broader benefits at reduced cost, Ocean State threatened the entrenched traditional plan with active price and quality competition. In a relatively short time, Ocean State began to attract an increasing number of physicians to the plan—one important factor (in addition to lower price) in expanding the plan's appeal to employers.

Blue Cross thereupon devised a formalized plan of attack on Ocean State. That plan had three components, as follows:

**A. "Prudent Buyer."**

Blue Cross announced that it would no longer pay a physician the full Blue Cross rates if the physician accepted lower rates from Ocean State. In essence, Blue Cross offered to pay *more* to any physician if he or she ceased participating in Ocean State's competing plan. The natural, probable, and intended effect of this strategy was that physicians would defect from Ocean State: many physicians simply could not afford to accept less for their services from Blue Cross (which, as a monopolist, provided the dominant share of their patients), so they had to quit Ocean State. To avoid further defections, Ocean State had to raise its payments to physicians, thus increasing its costs.

The Court of Appeals ignored the obvious anticompetitive intent and effect of this tactic and decided that the policy could be sustained as an attempt by Blue Cross to *reduce* payments to physicians who were willing to accept lower payments. Noting a reluctance "to interfere in the domain of medical costs," *Ocean State Physicians Health Plan v. Blue Cross*, 883 F.2d 1101, 1111 (1st Cir. 1989), the Court of Appeals held that a dominant firm, with power over physicians, can coerce those physicians not to deal with a new entrant, or not to offer economically sensible prices to the new entrant, so long as it does so by stating that it is imposing a lower price to match

that offered the new entrant. The Court's rule suggests that this is somehow different from the plainly pernicious practice of paying a physician bonuses if the physician agrees not to deal with the incipient competitor or agrees not to offer the competitor a lower price—even though the incipient competitor may need the lower price to survive. According to the Court of Appeals, it is of no matter that the purpose and effect of the tactic in both cases would be exclusionary.

The Court of Appeals' attempt to posit an efficiency justification and to use it to override the jury verdict that Blue Cross' conduct was an attempt to impose higher costs on a weaker competitor, flouts the tenets of economic efficiency and consumer welfare embodied in Section 2 of the Sherman Act. In the absence of the exclusionary plan, physicians would have remained free to charge lower prices to Ocean State (a practice that is clearly economically rational from the *physician's* perspective, in order to increase the physician's total earnings) and thereby increase consumer choice among competing plans. In the presence of Blue Cross' exclusionary plan, however, the reverse would occur: Blue Cross would effectively maintain its (high) prices to physicians who defected from Ocean State, and Ocean State's ability to offer a lowered price alternative would be undermined by having to choose between operating with fewer physicians (making its plan less attractive to consumers) or matching Blue Cross' higher rates.

Blue Cross could not have been unaware of the natural and probable effect of its approach—to cause physicians to quit Ocean State, or cause Ocean State to raise its prices. Such conduct is roughly analogous to an unlawful exclusive dealing arrangement or boycott where the monopoly buyer conditions the availability of high-priced purchases (desired by supplier-physicians) on the discontinued patronage of a competitor. It is not similar to cases dealing with price reductions to the ultimate con-

sumer, which the Court of Appeals seemed to have in mind when it raised lower price as a justification for sustaining the conduct. Here, the undisputed effect of Blue Cross' conduct was to exclude or weaken a low cost supplier of health care services. The exclusionary aspect of the plan was clear. The issue of the use of predatory purchasing power to maintain a monopoly in the health care field deserves the attention of the Court.

### B. "HealthMate."

The second prong of Blue Cross' effort to thwart competition from Ocean State was to set up a look-alike HMO, a "fighting ship," which it marketed *only* to employers who also offered or were known to be considering the Ocean State plan, and only as an adjunct to an employer's purchase of the traditional Blue Cross plan. Blue Cross did not consider HealthMate to be financially viable in the long run, though it was effective in thwarting the growth of its competitor's business. HealthMate was marketed by offering discounts on the *traditional* Blue Cross plan (the monopoly plan that employers realistically could not refuse) *if* employers would offer HealthMate to their employees as a further alternative to Ocean State's HMO. Blue Cross offered even lower rates if those employers got rid of Ocean State altogether and ceased to offer it to their employees.

### C. Adverse Selection.

Under Blue Cross' "Adverse Selection" policy, Blue Cross used the rates for its traditional plan—the one plan that employers could not be without—as a lever in connection with the employer's choice of HMO: "The rate was lowest for an employer who offered *only* traditional Blue Cross, intermediate for an employer who also offered a competing HMO (usually Ocean State) and HealthMate, and highest for an employer who also

offered a competing HMO but declined to offer HealthMate." 883 F.2d at 1103 (emphasis in original).

The asserted justification for this tactic—that healthier employees in the groups might tend to favor HMOs, leaving Blue Cross with an unhealthier group of employees—is facially plausible, but was not supported by any actuarial estimate of the size of any adverse selection factor or any determination that the rates set were reasonable on that basis. Certainly this conduct could not be shown to be "no more restrictive than necessary"—the standard test for judging a monopolist's conduct that has an exclusionary effect. The explanation for the differential charge where HealthMate was not offered, and where HealthMate was offered by the employer in conjunction with Ocean State, was left unexplained. The reason why, if the rates were reasonably balanced, HealthMate was not offered along with Blue Cross unless the employer was considering Ocean State, was also not explained.

The natural, probable and intended effect of Blue Cross' tactic was clearly discernible: to exclude Ocean State. The use of discriminatory pricing by the powerful Blue Cross plan—the plan that employers effectively were required to carry—in order to lever those employers into offering HealthMate or abandoning Ocean State, is rendered further suspect by the limited marketing of HealthMate only to employers who were offering Ocean State. This was not an attempt to attract employers to Blue Cross products because of their competitive merits. It can only be seen, and was seen by the jury, as an attempt to force employers to forego their decision to offer a competing health plan, and thereby restrict the growth of a competitor. The court below conceded as much. 883 F.2d at 1104, n.4. And again, it could only be effective by virtue of the monopolist's market power.

Nonetheless, the Court of Appeals found that all issues relating to the decision to market HealthMate, the man-

ner of marketing HealthMate, and the rate differentials, were the "business of insurance," and thus exempt from the antitrust laws under the McCarran-Ferguson Act. The McCarran-Ferguson exemption is "inapplicable to any . . . act of boycott, coercion, or intimidation"; but the court rejected the contention that there was any coercion. The court found no coercion because Blue Cross did not leave the employers "*no* choice" in the matter; employers merely faced, in a plan that they could not realistically reject, rate increases that were "greater than they otherwise would have been." [4] *Id.* at 1109.

The court below turns a blind eye to the inherent power of a monopolist when the court suggests that the monopolist is not exercising coercion when it employs its monopoly power in the way Blue Cross did here. Use of market power, in the form of price differentials for the product of the monopolist—a product which employers, in a very real sense, are virtually compelled to purchase irrespective of price—puts significant economic pressure on those employers. Indeed, price differentials that penalize those who deal with one's competitors have long been recognized as "coercive" for purposes of the Sherman Act. *E.g., United States Navigation Co. v. Cunard S.S. Co.*, 284 U.S. 474, 479-80 (1932). Congress certainly had this Sherman Act meaning for the term "coercion" in mind when it enacted the McCarran-Ferguson Act and affirmatively made "coercive" insurance activity subject to the Sherman Act.

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[4] The Court of Appeals also expressed the view that Ocean State had waived the coercion argument by not raising it in its initial brief on appeal. This suggestion would not prevent review of that issue in this Court. The district court did not decide the case under McCarran-Ferguson, and there was thus no reason to discuss the inapplicability of McCarran-Ferguson in the opening brief. Moreover, it is plain that the Court of Appeals did, in fact, consider the issue on the merits, purporting to state a view with binding precedential effect. It did not rely on the supposed procedural default to preclude consideration of the issue in that court, and thus it is no bar in this Court.

To suggest that the monopolist is not employing coercion when it imposes a price penalty on those who deal with a potential competitor is simply to deny the meaning of monopoly power. Here we must assume that the adverse selection policy, although rational in basic conception, was not justifiable in fact—that is what the jury found. Similarly, the manner in which Blue Cross used access to its traditional plan to foist HealthMate on employers also involved a clear use of Blue Cross' monopoly power. The "coercion" exemption from McCarran-Ferguson is of vital significance in considering the actions of a monopolist "insurer", and is of vital importance, given the dominant role of the traditional plans in the health care field.

But even if the "insurance" aspects of Blue Cross' strategy were protected standing alone, this Court has made it clear that an anticompetitive plan is not to be judged "by dismembering it and viewing its separate parts, but only by looking at it as a whole." *United States v. Patten*, 226 U.S. 525, 544 (1913). *See Continental Ore Co. v. Union Carbide & Carbon Corp.*, 370 U.S. 690, 698-99 (1962). It is one thing to suggest that conduct that is subject to some statutory exemption cannot, in itself, be a violation of the antitrust laws. It is quite another thing to suggest that where there is an active plan to monopolize, including several elements, all otherwise unlawful, the jury cannot consider exempt conduct as part of an overall scheme of which it is, *in fact*, a part. Nothing in the language of McCarran-Ferguson suggests that result; the exemption itself is phrased primarily in the form of an intention not to preempt state law. Therefore, if the "prudent buyer" policy is unlawful, and HealthMate and Adverse Selection part and parcel of a single plan of which that was one part, it may be sufficient to hold in this case that McCarran-Ferguson cannot exempt Blue Cross' overall scheme from the reach of the antitrust laws.

## CONCLUSION

The decision of the Court of Appeals simply ignores the power of the monopolist, and sanctions the abuse of monopoly power, power that is real and tangible to those that are its victims. Here, as plausibly found by a jury, monopoly power was used to quash potential competition and maintain a monopoly. Kaiser is concerned about the decision because it presents a blueprint for the maintenance of monopoly power that is readily applicable to other markets and involves an important segment of the health care industry. The issues presented are of importance to the promotion of competition in that industry and to a proper understanding of Section 2 of the Sherman Act. Therefore, the writ of certiorari should be issued by this Court to review the judgment of the United States Court of Appeals for the First Circuit.

Respectfully submitted,

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